



General Information for Authorization

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Instructions to fill out the General Information for Authorization form, DSHS 13-835

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3	Name: Required.	Enter the last name, first name, and middle initial of the patient you are requesting authorization for.
4	Client ID: Required.	Enter the client ID = 9 numbers followed by WA. For Prior Authorization (PA) requests when the client ID is unknown (e.g. client eligibility pending): <ul style="list-style-type: none"> You will need to contact DSHS at 1-800-562-3022 and the appropriate extension of the Authorization Unit (See <u>contact section</u> for further instructions). A reference PA will be built with a placeholder client ID. If the PA is approved – once the client ID is known – you will need to contact DSHS either by fax or phone with the Client ID. The PA will be updated and you will be able to bill the services approved.
5	Living Arrangements	Indicate where your patient resides such as, home, group home, assisted living, skilled nursing facility, etc.
6	Reference Auth #	If requesting a change or extension to an existing authorization, please indicate the number in this field.
7	Requesting NPI #: Required.	The 10 digit numeric number that has been assigned to the requesting provider by CMS.
8	Requesting Fax#	The fax number of the requesting provider.
9	Servicing NPI #: Required.	The 10 digit numeric number that has been assigned to the billing/servicing provider by CMS.
10	Name	The name of the billing/servicing provider.
11	Referring NPI #	The 10 digit numeric number that has been assigned to the referring provider by CMS.
12	Referring Fax #	The fax number of the referring provider.
13	Service Start Date	The date the service is planned to be started if known.
15	Description of service being requested: Required.	A short description of the service you are requesting (examples, manual wheelchair, eyeglasses, hearing aid).
18	Serial/NEA#: Required for all DME repairs.	Enter the serial number of the equipment you are requesting repairs or modifications to or the NEA# to access the x-rays for this request.
20	Code Qualifier: Required.	Enter the letter corresponding to the code from below: T - CDT Proc Code C - CPT Proc Code D - DRG P - HCPCS Proc Code I - ICD-9/10 Proc Code R - Rev Code N - NDC-National Drug Code S - ICD-9/10 Diagnosis Code
21	National Code: Required.	Enter each service code of the item you are requesting authorization that correlates to the Code Qualifier entered.
22	Modifier	When appropriate enter a modifier.
23	# Units/Days Requested: Required.	Enter the number of units or days being requested for items that have a set allowable. (Refer to the program specific <u>Billing Instructions</u> for the appropriate unit/day designation for the service code entered).
24	\$ Amount Requested: Required.	Enter the dollar amount being requested for those service codes that do not have a set allowable. (Refer to the program specific <u>Billing Instructions</u> and <u>fee schedules</u> for assistance) Must be entered in dollars & cents with a decimal (e.g. \$400 should be entered as 400.00).
25	Part # (DME only): Required for all "By Report" codes requested.	Enter the manufacturer part # of the item requested.

26	Tooth or Quad#: Required for dental requests	Enter the tooth or quad number as listed below: QUAD 00 – full mouth 01 – upper arch 02 – lower arch 10 – upper right quadrant 20 – upper left quadrant 30 – lower left quadrant 40 – lower right quadrant Tooth # 1-36, A-T, AS-TS, 51-82 and SN
27	Diagnosis Code	Enter appropriate diagnosis code for condition.
28	Diagnosis name	Short description of the diagnosis.
29	Place of Service	Enter the appropriate two digit place of service code.
30	Comments	Enter any free form information you deem necessary.

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